Fairfax County Health Department
Authorization for Disclosure, Personal Care Representative, Method of Contact

DISCLOSURE AUTHORIZATION **Client's Name:** _____ **DOB:** ___/__/____

As the person signing this authorization, I understand that:

- The provision of treatment or payment cannot be conditioned on my signing of this authorization.
- Any health information re-disclosed by a recipient may no longer be protected by this authorization.
- The original or copy of the authorization shall be included in my medical record.
- I have a right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.

❑ I do **not** authorize disclosure of my health information to anyone, other than for treatment, payment and health care operations

I am authorizing the Fairfax County Health Department to disclose my health information to the following organization(s) or person(s) specified below:

Beginning Date	Expiration Date	Organization(s) or Person(s)	Purpose for Disclosure	Information to be Disclosed	Date Rescinded (by FCHD Staff)	Rescinded by (Staff Initials)

This information may be disclosed immediately.

PERSONAL CARE REPRESENTATIVE

❑ I do not authorize anyone to act as my personal representative

❑ I authorize you to discuss my health information with the following individual(s) acting as my personal care representative:

Name and Relationship of Personal Care Representative:	

ALTERNATIVE METHOD OF CONTACT

❑ I would like to be contacted at the address and/or phone number you have on file in my health record.

❑ I prefer that you contact me in a way other than my home address and/or phone number. I wish to be contacted in the following manner:

Alternative Contact Information:	

_____ _____

Print Name Date

_____ _____

Signature Relationship to Client

This form must be reviewed with the client at least annually:

Date Reviewed	Staff Initials

Instructions for Completing the Form

1. Disclosure Authorization :
    a. Name and DOB is for the client being served.
    b. If you do not wish to give authorization to the Health Department to share your health information with anyone other than for treatment, payment or health care operations check the first box.
    c. If you do authorize the Health Department to share your health information with a person or organization for purposes other than treatment, payment or health care operations provide the detailed information in the chart.

2. Personal Care Representative:
    a. Indicate whether you want to designate an individual as your Personal Care Representative by checking the appropriate box.
    b. The Personal Care Representative has the same power over your protected health information, including the right to inspect your records, authorize disclosures and request amendments of your record.

3. Alternative Method of Contact:
    a. You can designate an alternative method of contacting you. You should check the first box if you want us to contact you at the home address or phone number documented in your health record.
    b. If you want us to contact you at an address or phone number other than what is documented in your health record check the second box and provide the alternate contact information.